DOCUMENT RESUME

ED 146 509 CG 011 943

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TITLE Anxiety and Assertive Training: A Program Evaluation and Therapy Outcome Study.
PUB DATE Apr 77
NOTE 15p.; Paper presented at the Annual Meeting of the Western Psychological Association (Seattle, Washington, April 1977)

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS Affective Behavior; *Anxiety; *Assertiveness; Behavioral Science Research; *Behavior Change; *Feedback; Program Descriptions; *Psychological Patterns; Research Methodology; *Training; Workshops
IDENTIFIERS *Reciprocal Inhibition Therapy

ABSTRACT

This paper describes the results of a study to: (1) design and evaluate three clinically practicable (e.g., non-analogue) regimens which emphasize treatment components of either behavioral rehearsal and feedback, anxiety management, or a combination of anxiety management and behavior reversal/feedback, and (2) examine the relative effectiveness of assertive training regimens that focus on learning versus performance deficits. Forty-six university students volunteered to participate in a three-week (nine-hour) assertive training workshop. Subjects were pre-tested on two measures of assertiveness and two measures of anxiety, and then randomly assigned to one of four conditions: (a) Assertive Training (AT): (b) Anxiety Management (AM): (c) Assertive Training and Anxiety Management (AT/AM); or (d) No Treatment Control (C). Subjects in the AT condition received five treatment components; AT/AM subjects received exactly the same treatment components plus training in additional anxiety management procedure; AM subjects were instructed in deep muscle relaxation. The results demonstrate the therapeutic effectiveness of three different assertive training regimens. All three treated groups consistently showed lower levels of anxiety and higher magnitudes of assertive behavior following treatment than did the control group. In addition, the behavioral measures showed a tendency for the AT group to be the most efficacious treatment strategy. (Author/PFS)

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ANXIETY AND ASSERTIVE TRAINING:
A PROGRAM EVALUATION AND THERAPY OUTCOME STUDY

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April 1977

Paper presented at the Western Psychological Association Meeting, April, 1977.

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Anxiety Management Techniques
in Assertive Training Groups: An Empirical Evaluation

Bandura (1969) makes use of a theoretical distinction between learning and performance to account for a variety of behavioral deficits. Using this conceptual scheme (i.e., learning versus performance) to examine the existing assertive training literature, a heuristic dichotomy emerges. It appears that researchers have either presumed unassertive behavior to be a function of a learning deficit (Eisler and Hersen, 1973; Hersen, Eisler, Miller, Johnson and Pinkston, 1973), or a performance deficit (Palmer, 1973; Wolpe, 1969; Wolpe and Lazarus, 1966).

An assertive performance deficit model would suggest that the lack of assertive behavior is the function of response inhibition, such that previously learned assertive responses are not performed. On the other hand, a learning deficit model implies that specific assertive responses are simply never learned in the first place. In spite of these differences in theoretical outlook, assertive training procedures developed by both groups of researchers contain identical treatment components (viz, behavior rehearsal, modeling, coaching, instructions, and reinforcement). Differences among treatment strategies appear primarily in the theoretical rationales employed to justify a particular treatment regimen, rather than in the actual treatment components employed. For example, researchers subscribing to the learning deficit theory maintain that the primary function of behavior rehearsal is to shape and reinforce new behavior patterns (Hersen, et al., 1973), while those adhering to the performance deficit theory proclaim the function of their behavior rehearsal procedures to be an "in vivo" desensitization (Wolpe, 1969).

Clearly, behavior rehearsal can function as both an in vivo desensitiza-

tion and as a procedure to shape new behavior patterns. Nonetheless, if a performance deficit (maintained by situational anxiety) accounts for a major portion of the variability in unassertive behavior, then one would expect that a reduction of anxiety associated with assertive interpersonal interactions would facilitate assertive behavior. On the other hand, if unassertive behavior is primarily the function of a learning deficit, then additional training in "how to be assertive" may be required to effect increases in assertive behavior. Furthermore, if both performance and learning deficits contribute significantly to the maintenance of unassertive behavior, then a combination of reduced anxiety and behavioral training might be required to facilitate maximal assertive behavior.

Most investigators in the area of assertive training acknowledge the importance of anxiety as an intervening variable that, in part, contributes to the maintenance of unassertive behavior. However, in spite of the hypothesized roled played by situational anxiety, seldom are therapeutic techniques used which are intended to directly reduce the subject's level of anxiety (e.g., Desensitization, Relaxation Training, or Anxiety Management Training). Research in this area may have been inhibited by the theoretical model posited by Wolpe (1969). He contended that assertiveness reciprocally inhibits anxiety (i.e., if one is assertive, then one cannot be anxious). If, in fact, assertiveness reciprocally inhibits anxiety, then techniques intended to promote and reinforce assertive behavior would be sufficient to reduce situational anxiety, and additional anxiety management procedures would be superflous. The existing literature is replete with demonstrations of significant increases in assertiveness and concomitant reduction in anxiety level as a function of training assertive behavior (Galassi and Galassi, 1974; McFall and Marston,

1970; Rathus, 1973). Nonetheless, the other side of the theoretical coin has not been put to the empirical test. Namely, if a treatment regimen is designed specifically to reduce the client's anxiety level, but does not train behaviorally "how to be" assertive, will the subject then behave more assertively (i.e., the performance deficit theory)?

Although several authors have reported the use of desensitization or similar anxiety management techniques as adjuncts to assertive training (D'Zurrilla, 1969; Geisinger, 1969; Lazarus, 1968, 1971, 1973), only one author has sought to compare the relative efficacy of an anxiety management technique and assertive training. Seber and Nelson (1971) treated 24 psychiatric cases with either systematic desensitization or assertive training. Unfortunately, Seber and Nelson concluded that neither assertive training nor desensitization were effective with their particular sample of hospitalized schizophrenics.

Noting the lack of information regarding the usefulness of an anxiety management component in assertive training regimen, the present study's purposes are twofold. First, to design and evaluate three clinically practicable (e.g., non-analogue) regimens which emphasize treatment components of either behavior rehearsal and feedback, anxiety management, or a combination of anxiety management and behavior rehearsal/feedback. Secondly, the study will examine the relative effectiveness of treatments that focus on learning versus performance deficits.

Forty six university students volunteered to participate in a three week (9 hour) assertive training workshop. Subjects were pre-tested in two measures of assertiveness (a Behavioral Role Play Test and the College Self Expression Scale), and two measures of anxiety (State/Trait Anxiety Inventory), and then

randomly assigned to one of four conditions: (a) Assertive Training (AT); (b) Anxiety Management (AM); (c) Assertive Training and Anxiety Management (AT/AM); or (d) No Treatment Control (C).

Subjects in the AT condition received five treatment components: 1) behavior rehearsal, 2) coaching, 3) performance feedback, 4) lecture and discussion, and 5) homework assignments. Subjects in the AT/AM condition received exactly the same treatment components as the AT condition plus training in an additional anxiety management procedure (i.e., a modification of Jacobsonian deep muscle relaxation).

The subjects in the AM condition were instructed in deep muscle relaxation and asked to covertly practice it's application in the same rehearsal situations used in the AT/AM condition. The treatment components in this condition included: (a) covert rehearsal, (b) training in anxiety management, (c) lecture and discussion, and (d) homework assignments. Unlike the AT and AT/AM conditions, the AM subjects did not receive covert rehearsal, coaching, or performance feedback.

The data analyses revealed therapeutic effectiveness of three different assertive training regimens. Treated groups receiving assertive training, anxiety management, or a combination of the two procedures, consistently showed lower levels of anxiety and higher magnitudes of assertive behavior following treatment than did the control group (see Table 1). Looking solely at the self-report criterion measures used in the present study, the therapeutic potency of the three modes employed appear quite similar. All treatments were effective in reducing both general anxiety and the anxiety associated with assertive interactions. Similarly, all treatments were potent in effecting increases in <u>self-reported</u> assertiveness (viz, CSES and self-ratings).

However, if one looks at the data generated from behavioral observations, some notable differences emerge. At the post-test, at the AT group's verbal responses in social interaction were judged to be significantly more assertive than the AT/AM group's responses. Furthermore, at the follow-up assessment, the raters judged the AT group to be significantly more assertive than all other treatment conditions. In addition, raters determined that the AT group was using significantly more personal pronouns at the post-test than either the AM or AT/AM conditions.

In contrast to the AT results the AM group's level of assertiveness (i.e., behavioral ratings) had not increased significantly from pre- to follow-up assessment. Similarly, while the AT and AT/AM groups showed significant with-in-group increases in the use of personal pronouns (from pre- to post- to follow-up assessment), neither the AM nor the control group demonstrated reliable changes. Moreover, the mean frequency of personal pronouns used by the AM and control groups did not differ significantly from one another at either the post or follow-up assessment.

Conclusions regarding the usefulness of an anxiety management component should be drawn cautiously from the present study. It should be reiterated that the AT/AM condition was not simply the AT procedures plus the anxiety management procedures. In order to include the AM techniques and keep time in therapy constant across conditions, one 20 minute behavioral rehearsal section was removed from each (AT) session and replaced with training in deep muscle relaxation. The resulting AT/AM condition was, in fact, some of the AT and some of the AM procedures. The aforementioned cautions notwithstanding, apparently the anxiety management techniques used in the present study added little to the treatment potency of the AT procedures, and may have muted their

effectiveness. Nevertheless, the data demonstrate that the removal of one block of assertive performance (i.e., situational anxiety) can significantly facilitate assertive responses.

These data further colloborate Wolpe's (1969) theory of the reciprocally inhibitory relationship between anxiety and assertiveness. Subjects encouraged to behave assertively (AT), subsequently reported lower anxiety levels; conversely, subjects whose situational anxiety level was directly reduced (AM) demonstrated increases in assertive behavior. Undoubtedly, both learning and performance deficits maintain unassertive behavior. Components which remove the blocks to assertive performance (AM), or encouraged new learning (AT), resulted in significant increases in assertive behavior and concomitant reductions in anxiety. However, this study and its conclusions do not take into account individual differences. It seems likely that highly anxious clients could benefit from, if not require, anxiety management training before attempting to rehearse assertive responses. On the other hand, relaxation procedures may be superfluous with low anxious clients. Ideally, a therapist needs to know what combination of techniques are effective with which clients. The relative contributions of learning and performance deficits (for each individual client) may be important diagnostic data upon which to build an effective treatment regimen. The author currently is investigating the differential effectiveness of adjunctive anxiety management procedures with high and low anxious, unassertive clients.

Few authors, in the area of assertive training, have gathered systematic follow-up data and those that have report similar findings. Differences between treated and control groups begin to fade shortly after treatment termination. (Friedman, 1971; Hedquist & Weinhold, 1970; McFall & Lillesand, 1971;

McFall & Marston, 1970; McFall & Twentyman, 1973). One is tempted to conclude that assertive training is only effective in changing assertive behavior during the treatment period and that minimal permanent change is affected.

The results of the present study are contradictory to this conclusion. At the one-month follow-up all treated groups were significantly more assertive than the control group on all dependent measures, with the exception of trait anxiety. Perhaps these antonymous findings can be understood in the light of the treatment procedures employed in previous studies. The majority of the studies that included a follow-up assessment have been treatment analogues. McFall and Twentyman (1973) note that they have limited themselves to a "narrow and fairly simple response class, a limited subject population and a relatively inflexible treatment program" (p. 217). The present study represents a move away from purely analogue-type research. Not only did the treatments more closely represent actual therapeutic conditions, but they lasted for a total of 9 hours, 4 hours longer than the longest reported treatment duration. Perhaps the maintenance of the treatment effects demonstrated in the present study are a result of the similarity of the current treatment procedures to actual therapy conditions.

Table 1

Means and Standard Deviations: By Criterion Means and Trials Across Conditions

Criterion Measure	Condition AT	AM	AT/AM	Control
CSES:				
Pre	112.54 (28.37)	96.00 (27.89)	104.91 (25.22)	106.40 (2055)
Post	157.01 (22.84)	139.70 (25.56)	137.90 (21.68)	110.70 (20.42)
Follow	161.36 (21.46)	144.10 (28.19)	142.36 (23.63)	120.90 (22.93)
Perceived Change:				
Post	3.73 (.75)	3.60 (.49)	3.64 (.77)	2.00 (.77)
Satisfaction:				
Post	4.55 (.65)	4.50 (.67)	4.27 (.86)	--
STAT-S:				
Pre	46.36 (12.13)	42.70 (13.33)	44.18 (12.54)	41.80 (5.16)
Post	30.64 (6.45)	29.00 (12.55)	32.18 (11.54)	40.80 (9.90)
Follow	26.36 (3.17)	31.10 (10.52)	31.64 (12.33)	38.80 (10.33)

Table 1
(continued)

Criterion Measure	Condition AT	AM	AT/AM	Control
STAT-T:				
Pre	44.82 (10.94)	49.00 (13.12)	44.00 (6.80)	43.30 (7.32
Post	35.64 (8.23)	36.30 (11.86)	36.00 (7.36)	44.80 (10.37)
Follow	33.09 (6.93)	36.50 (11.75)	35.00 (9.18	39.20 (7.39)
BRPT-Assertion:				
Pre	17.36 (5.65)	18.40 (7.34)	14.00 (4.98	16.30 (6.22)
Post	24.09 (5.03)	21.89 (4.17)	19.27 (3.85)	15.40 (5.06)
Follow	24.36 (3.91)	20.20 (3.97)	21.00 (5.35)	16.30 (4.69)
BRPT-Pronouns:				
Pre	23.27 (11.00)	25.20 (17.73)	18.09 (8.35)	16.30 (7.23)
Post	38.64 (22.01)	27.89 (15.21)	25.36 (7.30)	17.40 (4.35)
Follow	34.00 (15.13)	24.00 (10.62)	30.54 (19.25)	16.30 (5.58)

Note: Standard deviations are in parentheses. All comparisons between means were made with the use of the Newman-Keuls statistic. Means not underlined by a common line are statistically different from one another at or beyond the .05 level of significance.

References

Bandura A. Principles of behavior and modification. New York: Holt, Rinehart and Winston, 1979.

D'Zurilla, T. J. Ruducing heterosexual anxiety. In J. D. Krumboltz, and C. E. Thoresen (Eds.), Behavioral counseling: Cases and techniques. New York: Holt, Rinehard and Winston, 1969, 442-454.

Eisler, R. M., and Hersen, M. Behaviorial techniques in family-oriented crisis intervention. Archives of General Psychiatry, 1973, 28, 111-116.

Friedman, P. H. The effects of modeling and role playing on assertive behavior. In R. D. Rubin, H. Fensterheim, A. Lazarus, and C. Franks (Eds.), Advances in Behavior Therapy. New York: Academic Press, 1971.

Galassi, J. P., and Galassi, M. D. Assertive training in groups using video feedback. Journal of Counseling Psychology, 1974, in press.

Geinsinger, D. L. Controlling sexual and interpersonal anxieties. In J. D. Krumboltz, and C. E. Thorensen (Eds.), Behavioral counseling: Cases and techniques. New York: Holt, Rinehart and Winston, 1969, 454-469.

Hedquist, F. J., & Weinhold, B. K. Behavioral group counseling with socially anxious and unassertive college students. Journal of Counseling Psychology, 1970, 17, 237-242.

Hersen, M., Eisler, R. M., Miller, P. M., Johnson, M. B., and Pinkston, S. G. Effects of practice, instructions and modeling on components of assertive behavior. Behavior Research and Therapy. 1973, 11, 443-451.

Lazarus, A. On assertive behavior: A brief note. Behavior therapy, 1973, 4. 697-699.

Lazarus, A. Behavior Therapy and Beyond. New York: McGraw-Hill, 1971.

Lazarus, A. Behavior therapy in groups. In G. M. Gazda (Ed.), Basic approaches to group psychotherapy and group counseling. Springfield, IL: Charles G. Thomas, 1968, 149-175.

McFall, R. M., and Lillesand, D. B. Behavior rehearsal with modeling and coaching in assertion training. Journal of Abnormal Psychology, 1971, 77, 313-323.

McFall, R. M., and Twentyman, C. T. Four experiments on the relative contributions of rehearsal, modeling, and coaching to assertion training. Journal of Abnormal Psychology. 1973, 81, 199-218.

McFall, R. M., and Marston, A. R. An experimental investigation of behavior rehearsal in assertive training. Journal of Abnormal Psychology, 1970, 76, 295-303.

Palmer, R. D. Desensitization of the fear of expressing one's own inhibited aggression: Bioenergetic assertive techniques for behavior therapists. In Rubin, R. D., Brady, J. P., and Henderson, J. D. (Eds.), Advances in behavior therapy, Vol. 4. New York: Academic Press, 1973.

Rathus, S. A. Instigation of assertive behavior through videotaped-mediated assertive models and directed practice. Behavior Research and Therapy. 1973, 11, 57-65

Serber, M., and Nelson, P. The ineffectiveness of systematic desensitization and assertive training in hospitalized schizophrenics. Journal of behavior Therapy and Experimental Psychiatry. 1971, 2, 107-109.

Wolpe, J. The practice of behavior therapy. New York: Pergamon Press, 1969.

Wolpe, J., and Lazarus, A. Behavior therapy techniques: A guide to the treatment of neuroses. New York: Pergamon Press, 1966.